



AdvantEdge Program Application

APPLICANT INFORMATION (please print clearly)

Name: _____
Date of Birth: _____ Phone: (_____) _____ Mobile: (_____) _____
Address: _____
City: _____ State: _____ Zip: _____
Email: _____

HEALTH INSURANCE INFORMATION

Health Insurance Provider: _____
ID Number: _____

DIABETES PROGRAM INFORMATION

Receive eligible Diabetes Medication for FREE.
Enrollment in the Refill AdvantEdge Program.
Receive communication, including emails, updates and promotions related to Health & Wellness.
Review Diabetes AdvantEdge BG Log Sheet with a Price Chopper Pharmacist.

PRESCRIPTION INFORMATION

Prescription Number:	Medication Name:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

REFILL ADVANTEDGE

I understand that this program will allow me the opportunity to obtain automatic refills through Refill AdvantEdge and I would like to enroll in this program.

Preferred means of communication (select all that apply): Phone Text Email

Applicant Signature: _____ Date: _____

Print Name: _____

**Automatic refilling of prescriptions for prescription drugs is not allowed under the Medicaid Program.
Information will not be shared with third parties.**